FRAMEWORK FOR STATE EVALUATION
OF CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory: ***DELAWARE***
(Name of State/Territory)

The following State Evaluation is submitted in compliance with Title XXI of the Social Security Act (Section 2108(b)).

Elaine Archangelo, Director, Division of Social Services

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Contact Person/Title: David R. Michalik, Social Service Senior Administrator

Address: Medical Assistance Program, Division of Social Services, P.O. Box 906, New Castle, DE 19720

Phone (302) 577-4880, ext. 144 Fax (302) 577-4899

Email dmichalik@state.de.us

Section 1. Summary of Key Accomplishments of Delaware's SCHIP Program

This section is designed to highlight the key accomplishments of Delaware's SCHIP during Federal Fiscal Year 1999 (2/1/99 - 9/30/99) toward increasing the number of children with creditable health coverage (Section 2108(b)(1)(A)). This section also identifies strategic objectives, performance goals, and performance measures for the SCHIP, as well as progress and barriers toward meeting those goals. More detailed analysis of program effectiveness in reducing the number of uninsured low-income children is given in sections that follow.

1.1 What is the estimated baseline number of uncovered low-income children? Is this estimated baseline the same number submitted to HCFA in the 1998 annual report *(N/A for Delaware as the SCHIP program known as the Delaware Healthy Children Program [DHCP] only became operational in FFY '99).* If not, what estimate did you submit, and why is it different?

Delaware's initial estimate of 10513, ±2000, children was based on a study by the University of Delaware's Center for Applied Demographic and Survey which resulted in them applying a percentage of the total State population, based on national experience that 10% of the population is uninsured. They then determined the number of children under age 19 with family incomes under 200% of the FPL. It was also estimated that there were 4,000 uninsured children under 100% of the FPL who should have been eligible for Medicaid but were not enrolled in Title XIX. The estimate for SCHIP eligibles has been increased to 13000, ±2000, due to an increase in the State's population from an estimated 738,000 to an estimated 750,000.

1.1.1 What are the data source(s) and methodology used to make this estimate?

The University of Delaware's Center for Applied Demographic and Survey Research (U of D CADSR).

1.1.2 What is the State's assessment of the reliability of the baseline estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

This group is the authority upon which the State's Health Care Commission and Medicaid rely for data. We believe this is within a ±5% confidence interval.

1.2 How much progress has been made in increasing the number of children with creditable health coverage (for example, changes in uninsured rates, Title XXI enrollment levels, estimates of children enrolled in Medicaid as a result of Title XXI outreach, anti-crowd-out efforts)? How many more children have creditable coverage following the implementation of Title XXI? (Section 2108(b)(1)(A))

If all eligibles for the Delaware Healthy Children Program (DHCP) were enrolled, there would be only 5% of the State's total population of children still uninsured. Many children not enrolled in Medicaid, DHCP or private insurance plans are covered by a private foundation, the Nemours Foundation, for medical care. Through 9/30/1999, 3,474 children were enrolled in the Delaware Healthy Children Program for a 33% penetration rate in the first seven (7) months of the program. In addition, 2124 children were added to Medicaid through the DHCP outreach efforts.

1.2.1 What are the data source(s) and methodology used to make this estimate?

The Medicaid Budget, Statistical & Systems Unit of the Delaware Division of Social Services with input from the U of D CADSR.

1.2.2 What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Delaware believes that this is accurate with in the range of ±5% confidence interval. The limitations of the methodology are due to the size of the State; since Delaware is so small, the numbers are not statistically significant and therefore not fully reliable without a survey. Therefore, Delaware applies national trends to State data.

1.3 What progress has been made to achieve the State's strategic objectives and performance goals for its SCHIP program(s)? *See Table 1.3.*

Table 1.3

(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
To decrease the number of uninsured children and thereby improve their health and chances for life success	*Show rate of uninsured children*	Data Sources: *Budget, Statistical & Systems Unit* Methodology: *Tracking enrollment v. Universe of eligible children 101-200% FPL* Numerator: *# of children enrolled in FFY '99 = 3,474 DHCP + 2,124 children added to Medicaid = 5,598 children who received some coverage during FFY '99* Denominator: *Universe of uninsured children with family incomes between 101% & 200% of FPL not already in Medicaid = 14,513 (10,513 DHCP + 4,000 Medicaid)* Progress Summary: *33% SCHIP enrollment rate in year one; total number of uninsured children cut by 39% in FFY'99 (5598/14,513)*
None specified in Plan		
OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT		

Table 1.3		
None specified in Plan		

OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)		
To go from a clinical based system (fee-for-service/sick care) to a community-based system (managed care/preventive care) which provides genuine access to high quality care.	*Percentage decline in unnecessary emergency room visits.*	Data Sources: *MCO encounter data & baseline survey* Methodology: *DB2 queries* Numerator: *# of ER visits after enrollment (not available at this time)* Denominator: *# of projected ER visits prior to SCHIP* Progress Summary: *% reduction in ER visits not yet available; program too new in this reporting period; encounter data not available.*
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		
To mainstream uninsured children in the health care industry so they receive the same quality of care as uninsured children	*Percentage increase in wellness visits*	Data Sources: *MCO encounter data & baseline survey* Methodology: *DB2 queries* Numerator: *# of well child visits after enrollment (not available at this time)* Denominator: *# of projected well child visits prior to SCHIP* Progress Summary: *% increase in well child visits not yet available; program too new in this reporting period; encounter data not available.*

SECTION 2. BACKGROUND

This section is designed to provide background information on SCHIP program(s) funded through Title XXI.

2.1 How are Title XXI funds being used in *Delaware*?

2.1.1 List all programs in *Delaware* that are funded through Title XXI. (Check all that apply.)

___ Providing expanded eligibility under the State's Medicaid plan (Medicaid SCHIP expansion)
Name of program: _____
Date enrollment began (i.e., when children first became eligible to receive services):
_____

_√_ Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (State-designed SCHIP program)
Name of program: *Delaware Healthy Children Program (DHCP)*
Date enrollment began (i.e., when children first became eligible to receive services):
February 1, 1999

___ Other - Family Coverage
Name of program: _____
Date enrollment began (i.e., when children first became eligible to receive services):
_____

___ Other - Employer-sponsored Insurance Coverage
Name of program: _____
Date enrollment began (i.e., when children first became eligible to receive services):
_____

_*_ Other - Wraparound Benefit Package
Name of program: *Delaware's wrap-arounds are part of DHCP and not a separate program*
Date enrollment began (i.e., when children first became eligible to receive services):
_____

___ Other (specify) _____
Name of program: _____
Date enrollment began (i.e., when children first became eligible to receive services):
_____

2.1.2 **If State offers family coverage:** Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP programs. *N/A*

2.1.3 **If State has a buy-in program for employer-sponsored insurance:** Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP programs. *N/A*

2.2 What environmental factors in *Delaware* affect the SCHIP program? (Section 2108(b)(1)(E))

2.2.1 How did pre-existing programs (including Medicaid) affect the design of *Delaware's* SCHIP program(s)?

Delaware Medicaid was already covering children up to age 19 with family income £ 100% of the FPL. Delaware Medicaid also covers disabled children with personal income £ 250% of the SSI benefit limit. The Nemours Foundation covered children not eligible for Medicaid up to approximately 175% of FPL. With the implementation of the DHCP, Nemours was encouraged to increase their income base.

2.2.2 Were any of the preexisting programs "State-only" and if so what has happened to that program?

_√_ No pre-existing programs were "State-only"

___ One or more pre-existing programs were "State only" ! Describe current status of program(s): Is it still enrolling children? What is its target group? Was it folded into SCHIP?

2.2.3 Describe changes and trends in the State since implementation of *Delaware's* Title XXI program that "affect the provision of accessible, affordable, quality health insurance and healthcare for children." (Section 2108(b)(1)(E))

_√_ Changes to the Medicaid program
- ___ Presumptive eligibility for children
- _*_ Coverage of Supplemental Security Income (SSI) children
- _√_ Provision of continuous coverage (specify number of months _*6*__)
- _*_ Elimination of assets tests
- _*_ Elimination of face-to-face eligibility interviews
- _√_ Easing of documentation requirements

***** *Delaware Medicaid already had these provisions – no change due to Title XXI*

_√_ Impact of welfare reform on Medicaid enrollment and changes to AFDC/TANF (specify)___*Added 1931 group of eligibles and implemented 24 months of transitional coverage for those leaving TANF roles*_____

_√_ Changes in the private insurance market that could affect affordability of or accessibility to private health insurance
- _√_ Health insurance premium rate increases
- ___ Legal or regulatory changes related to insurance
- ___ Changes in insurance carrier participation (e.g., new carriers entering market or existing carriers exiting market)
- _√_ Changes in employee cost-sharing for insurance
- ___ Availability of subsidies for adult coverage
- ___ Other (specify) _____

___ Changes in the delivery system
- ___ Changes in extent of managed care penetration (e.g., changes in HMO, IPA, PPO activity)
- ___ Changes in hospital marketplace (e.g., closure, conversion, merger)
- ___ Other (specify) _____

___ Development of new health care programs or services for targeted low-income children (specify) _____*N/A*_____

_√_ Changes in the demographic or socioeconomic context

___ Changes in population characteristics, such as racial/ethnic mix or immigrant status (specify)_____

_√_ Changes in economic circumstances, such as unemployment rate (specify) *Unemployment is at a 30-year low of 2%*_____

_√_ Other (specify) _*Population increase from estimated 738,000 to 750,000*_

_√_ Other (specify) _____

SECTION 3. PROGRAM DESIGN

This section is designed to provide a description of the elements of *Delaware* State Plan, including eligibility, benefits, delivery system, cost-sharing, outreach, coordination with other programs, and anti-crowd-out provisions.

3.1 Who is eligible?

3.1.1 In Table 3.1.1 and the following attachment, find a description of the standards used to determine eligibility of targeted low-income children for child health assistance under the plan.

Table 3.1.1

	State-designed SCHIP Program
Geographic area served by the plan (Section 2108(b)(1)(B)(iv))	*Entire State*
Age	*0 - 19*
Income (define countable income)	*101% - 200% FPL* *See attached*
Resources (including any standards relating to spend downs and disposition of resources)	*N/A*
Residency requirements	*Current State resident*
Disability status	*N/A*
Access to or coverage under other health coverage (Section 2108(b)(1)(B)(i))	*Uninsured 6 months or more before application unless loss for good cause*
Other standards (identify and describe)	*See attached*

Attachment to Table 3.1.1

Definition of countable income:

Eligibility is established using gross income of all immediate family members living in the same household with:*

- *a standard $90 disregard per earner,*
- *a disregard for the amount of actual child care expenses up to $175 for children age 2 and above and $200 for children under age two.*
- *a disregard of the first $50 of child support for any potentially eligible children.*

The resultant countable income is compared to 200% of the FPL for a family the size of those in the immediate family with one exception (a pregnant woman will count as two [2] people for determining the FPL level to use).

Income less than or equal to 200% of the FPL will qualify the children for eligibility for The Delaware Healthy Children Program.

** "Immediate family" is defined as a unit (living in the same household) comprised of various adults who are legally/financially responsible for each other, and various children (related or unrelated) for whom the adults have legal responsibility or for whom the adults have accepted parental-like responsibility. This is the same definition that is used for Medicaid eligibility.*

Other eligibility standards:

Eligible children must:

- *be citizens of the United States or have legally resided in the US for at least 5 years if their date of entrance into the US is 8/22/96 or*
- *meet the Personal Responsibility and Work Opportunity Reconciliation Act of 1997 (PRWORA) definition of qualified alien; and*
- *be ineligible for enrollment in any public group health plan.*

3.1.2 How often is eligibility redetermined?

Table 3.1.2	
Redetermination	State-designed SCHIP Program
Monthly	
Every six months	
Every twelve months	√
Other (specify)	

3.1.3 Is eligibility guaranteed for a specified period of time regardless of income changes? (Section 2108(b)(1)(B)(v))

_√_ Yes ° Which program(s)? *Delaware Healthy Children Program*
For how long? *1 year if per family per month premiums paid*
___ No

3.1.4 Does the SCHIP program provide retroactive eligibility?

___ Yes ° Which program(s)?
How many months look-back?
_√_ No

3.1.5 Does the SCHIP program have presumptive eligibility?

___ Yes ° Which program(s)?
Which populations?
Who determines?
_√_ No

3.1.6 Does *Delaware's* Medicaid program and SCHIP program have a joint application?

_√_ Yes ° Is the joint application used to determine eligibility for other State programs? If yes, specify. *N/A*
___ No

3.1.7 What are the strengths and weaknesses of *Delaware's* eligibility determination process in increasing creditable health coverage among targeted low-income children

Strengths:

1. *800 # is used on all brochures, applications and outreach materials. 800# is answered by competent staff who assist the callers with completing an application which can be mailed in. No face to face interviews are required.*
2. *We eliminated all verifications except income. It must be verified.*
3. *We have a simplified joint application. Families apply for health insurance either Medicaid or SCHIP. Parents can apply for themselves as well as children on the application. Medicare Beneficiaries can apply using the same application. We supply a postage paid envelope for convenience.*
4. *We use a centralized location to receive the applications that allows us to track them, prescreen for completeness, eligibility, etc. before they are transferred to a social worker for processing.*
5. *Six seasonal positions were approved to exclusively process SCHIP/Medicaid applications.*
6. *Our eligibility determination system automatically will determine if families are eligible for Medicaid or SCHIP. If a family becomes ineligible for Medicaid, the system will automatically cascade the children into SCHIP without a separate determination. Family does not have to reapply.*
7. *Process to notify families about choosing an managed care provider, paying a premium, covered services occurs quickly after eligibility has been determined. Families can pay a premium by mail or at a payment site.*
8. *All forms are translated into Spanish. Staff answering the 800# are bi-lingual.*
9. *The Covering Kids project uses community-based organizations to publicize health insurance and assist families in completing applications.*

Weaknesses:

1. *Because of tight labor market, we have experienced difficulty in attracting and maintaining staff to process applications and processing times exceed the optimum of 10 days, but remain within the mandated 45.*
2. *We were funded for 6 casual seasonal positions and currently only 3 are filled. There are no benefits and positions can only be filled full time for a year.*
3. *We experienced some problems implementing our new automated system. Initially some Medicaid eligible children were "cascading" into the SCHIP eligibility. Staff had a "learning curve" with the new system . Children's Medicaid eligibility has been restored.*

3.1.8 What are the strengths and weaknesses of *Delaware's* eligibility redetermination process in increasing creditable health coverage among targeted low-income children. How does the redetermination process differ from the initial eligibility determination process?

Strengths:

1. *As with applications, our eligibility determination system automatically will determine if families are eligible for Medicaid or SCHIP. If a family becomes ineligible for Medicaid, the system will automatically cascade the children into SCHIP without a separate determination.*

2. *Families receive notices if eligibility switches from free Medicaid to premium based SCHIP. Notices included detailed budget of income and family size.*

Weaknesses:

1. *Our automated eligibility system has one review date. If a working family is scheduled for a three month review of food stamps, they fail to provide the wage information, the system will close all programs of assistance, including Medicaid. SCHIP is guaranteed for 12 months so those cases do not close. Social Worker reopens the Medicaid if they review the closing notice. Or Social Worker reopens when family calls. We plan to correct this when funds allow*

2. *We would like to streamline the redetermination process. Families have to complete a blank application asking for same information like date of birth, social security numbers that we have already collected. When funds allow, we would like to implement a passive evaluation where families only complete the form when something has changed. Families living below or slightly above the poverty level have very complicated and challenging lives. Sometimes, it is difficult to make the time to complete another form. Eligible children lose coverage.*

3.2 What benefits do children receive and how is the delivery system structured? (Section 2108(b)(1)(B)(vi))

3.2.1 Benefits

Please see Table 3.2.1, showing which benefits are covered, the extent of cost sharing (if any), and benefit limits (if any).

Table 3.2.1 SCHIP Program Type *State Designed SCHIP Program*

Benefit	Is Service Covered? (Õ = yes)	Cost-Sharing (Specify) **NOTE*	Benefit Limits (Specify)
Inpatient hospital services	√		
Emergency hospital services	√		
Outpatient hospital services	√		
Physician services	√		
Clinic services	√		
Prescription drugs	√		
Over-the-counter medications	√		
Outpatient laboratory and radiology services	√		
Prenatal care	√		
Family planning services	√		
Inpatient mental health services	√		*31 days in combination with outpatient services beyond basic benefit of 30 days outpatient*
Outpatient mental health services	√		*See above*
Inpatient substance abuse treatment services	√		*See above*
Residential substance abuse treatment services	√		*See above*
Outpatient substance abuse treatment services	√		*See above*
Durable medical equipment	√		
Disposable medical supplies	√		
Preventive dental services			
Restorative dental services			
Hearing screening	√		
Hearing aids	√		
Vision screening	√		
Corrective lenses (including eyeglasses)	√		

* *Delaware has a per family per month premium only*

Benefit	Is Service Covered? (Õ = yes)	Cost-Sharing (Specify) *NOTE	Benefit Limits (Specify)
Developmental assessment	√		
Immunizations	√		
Well-baby visits	√		
Well-child visits	√		
Physical therapy	√		
Speech therapy	√		
Occupational therapy	√		
Physical rehabilitation services	√		
Podiatric services	√		
Chiropractic services	*		*If used by MCO*
Medical transportation	√		*Emergency only*
Home health services	√		
Nursing facility			
ICF/MR			
Hospice care	√		
Private duty nursing	√		*Up to 28 hours per week*
Personal care services			
Habilitative services	√		
Case management/Care coordination	√		
Non-emergency transportation			
Interpreter services			
Other (Specify) *Abortions*	√		*According to Hyde Amendment requirements*

* *Delaware has a per family per month premium only*

3.2.2 Scope and Range of Health Benefits (Section 2108(b)(1)(B)(ii))

Services are provided comparable to the service package for Medicaid children as of 12/98 except for the limitations on inpatient and outpatient mental health and substance abuse services (which are provided by the Department of Services to Children, Youth and Their Families once the DHCP benefit ends), and on private duty nursing. In addition, the DHCP does not cover dental or non-emergency transportation services. Although the DHCP does not cover nursing facility services, any child in need of these services would qualify for the Medicaid disabled children option.

3.2.3 Delivery System

See Table 3.2.3.

Table 3.2.3

Type of delivery system	State-designed SCHIP Program
A. Comprehensive risk managed care organizations (MCOs)	
Statewide?	_√_ Yes ___ No
Mandatory enrollment?	_√_ Yes ___ No
Number of MCOs	*3*
B. Primary care case management (PCCM) program	
C. Non-comprehensive risk contractors for selected services such as mental health, dental, or vision (specify services that are carved out to managed care, if applicable)	
D. Indemnity/fee-for-service (specify services that are carved out to FFS, if applicable)	• *Pharmacy,* • *Mental health & substance abuse services for 31 days beyond basic benefit of 30 outpatient days*

3.3 How much does SCHIP cost families?

3.3.1 Is cost sharing imposed on any of the families covered under the plan? (Cost sharing includes premiums, enrollment fees, deductibles, coinsurance / copayments, or other out-of-pocket expenses paid by the family.)

___ No, skip to section 3.4
_√_ Yes, check all that apply in Table 3.3.1

Table 3.3.1

Type of cost-sharing	State-designed SCHIP Program
Premiums	√
Enrollment fee	
Deductibles	
Coinsurance/copayments**	√ *$10 for inappropriate use of ER*

3.3.2 If premiums are charged: What is the level of premiums and how do they vary by program, income, family size, or other criteria?

$10 per family per month (PFPM) for families with incomes between 101% and 133% of the FPL,
$15 PFPM for families with incomes between 134% and 166% of the FPL, and
$25 PFPM for families with incomes between 167% and 200% of the FPL

Premiums are collected monthly. Premiums paid in advance earn one free month for every three months paid.

With a State Plan amendment that was effective 7/1/99, the 6 month lock-out for families who failed to pay premiums was eliminated.

3.3.3 **If premiums are charged:** Who may pay for the premium? Check all that apply. (Section 2108(b)(1)(B)(iii))

_√_ Employer
_√_ Family
_√_ Absent parent
_√_ Private donations/sponsorship
_√_ Other (specify) _____*anyone who wants to pay*_____

3.3.4 **If enrollment fee is charged:** What is the amount of the enrollment fee and how does it vary by program, income, family size, or other criteria? *N/A*

3.3.5 **If deductibles are charged:** What is the amount of deductibles (specify, including variations by program, health plan, type of service, and other criteria)? *N/A*

3.3.6 How are families notified of their cost-sharing requirements under SCHIP, including the 5 percent cap? *Program materials and letters from Health Benefits Manager notifying families that monthly premiums are due.*

3.3.7 How is *Delaware's* SCHIP program monitoring that annual aggregate cost-sharing does not exceed 5 percent of family income?

___ Shoebox method (families save records documenting cumulative level of cost sharing)
___ Health plan administration (health plans track cumulative level of cost sharing)
___ Audit and reconciliation (State performs audit of utilization and cost sharing)
_√_ Other (specify) *premiums are set at less than 5% of minimum income level, so can never exceed that limit*

3.3.8 What percent of families hit the 5 percent cap since *Delaware's* SCHIP program was implemented? *N/A*

3.3.9 Has *Delaware* undertaken any assessment of the effects of premiums on participation or the effects of cost sharing on utilization, and if so, what have you found?

Data is available, but the assessment of the effects of premium is incomplete. We are currently reviewing disenrollments and contacting the families to measure the effect of premiums on participation.

Approximately 50% of the disenrollments each month are from the lowest income families. However, 90% of these families have transitioned to the DHCP from Medicaid and their DHCP disenrollments can be due to: loss of eligibility, availability of other insurance coverage, Or confusion over the premium requirement that did not exist with Medicaid coverage.

It is also interesting that approximately 40% of monthly payments and 44% of clients taking advantage of a quarterly payment incentive (one free month) are from the lowest income level.

Currently, there are studies underway to assess the effect of premiums on disenrolled clients and clients who were approved as eligible but have not enrolled. In the upcoming months, Delaware will have meaningful data about the effects of premiums on participation.

3.4 How *does Delaware* reach and inform potential enrollees?

3.4.1 What client education and outreach approaches does *Delaware's* SCHIP program use?

See Table 3.4.1 identifying all of the client education and outreach approaches used by *Delaware's* SCHIP program rated for effectiveness of each approach on a scale of 1 to 5, where 1=least effective and 5=most effective.

Table 3.4.1		
Approach	State-Designed SCHIP Program	
	Õ = Yes	Rating (1-5)
Billboards	√	*5*
Brochures/flyers	√	*5*
Direct mail by State/enrollment broker/administrative contractor	√	*5*
Education sessions	√	*3*
Home visits by State/enrollment broker/administrative contractor		
Hotline	√	*5*
Incentives for education/outreach staff		
Incentives for enrollees		
Incentives for insurance agents		
Non-traditional hours for application intake		
Prime-time TV advertisements	√	*4*
Public access cable TV	√	*4*
Public transportation ads	√	*5*
Radio/newspaper/TV advertisement and PSAs	√	*5*
Signs/posters	√	*4*
State/broker initiated phone calls	√	*4*
Other (specify) *health fairs*	√	*2*
Other (specify) *letter from Governor & brochure to every public, private, parochial & home schooled student.*	√	*5*

3.4.2 Where does *Delaware's* SCHIP program conduct client education and outreach?

See Table 3.4.2 identifying all the settings used by *Delaware's* SCHIP program(s) for client education and outreach, specifying which settings are used and rating the effectiveness of each setting on a scale of 1 to 5, where 1=least effective and 5=most effective.

Table 3.4.2

Setting	State-Designed SCHIP Program	
	Ø = Yes	Rating (1-5)
Battered women shelters	√	*0*
Community sponsored events	√	*4*
Beneficiary's home		
Day care centers	√	*3*
Faith communities	√	*2*
Fast food restaurants		
Grocery stores	√	*2*
Homeless shelters	√	*4*
Job training centers	√	*5*
Laundromats		
Libraries		
Local/community health centers	√	*5*
Point of service/provider locations	√	*5*
Public meetings/health fairs	√	*3*
Public housing	√	*4*
Refugee resettlement programs		
Schools/adult education sites	√	*5*
Senior centers	√	*2*
Social service agency	√	*5*
Workplace	√	*3*
Other (specify) *Methadone Clinic*	√	*5*

3.4.3 Describe methods and indicators used to assess outreach effectiveness, such as the number of children enrolled relative to the particular target population. Please be as specific and detailed as possible. Attach reports or other documentation where available.

Outreach effectiveness is measured through tracking several indicators:

- *how our applicants heard about the DHCP. For instance, the distribution of information through the schools results in an increase in callers citing schools as their source of program information.*
- *received applications by zip code, indicating the effectiveness of outreach to different communities.*
- *the age of enrollees and the spread of family income levels*
- *statewide participants in 90 minute training sessions. Over 650 trainees have participated in the program overview: 48% from provider facilities, 25% from community organizations, including Legal Aid, the Food Bank, the Latin American Community Center, Stand for Children, YMCAs and YWCAs, Church groups, etc, 18% from government offices, including Departments of Social Service, Labor, Education, Child Mental Health, Child Support, Division of Aging and Adults with Physical Disabilities*

Please see attached tracking sheet for 1999 that indicates the source of referral. The question is asked of everyone who calls our 800 outreach number.

3.4.4 What communication approaches are being used to reach families of varying ethnic backgrounds?

The program application, outreach materials, and video are all available in Spanish. There are Spanish speaking representatives on the 800 information line, and community outreach/ enrollment partners from the Latino communities in Delaware. In addition, we attend ethnic fairs like the Hispanic Festivals to perform outreach. Through the Robert Wood Johnson Covering Kids initiative we implemented finders fees in the very last few days of FFY '99. These fees are paid to community-based organizations after they have successfully assisted a family through the eligibility process. The fee is paid per family enrolled in either Medicaid or SCHIP. Several community-based organizations that serve Hispanic or immigrant populations are participating in the finder's fee pilot. We have purchased print or air time on Spanish language radio stations and publications.

Delaware Healthy Children Program

How did applicants hear about the program?

Week Ending	#of Apps Mailed	Schools/ Daycare	Radio/ TV/Bus	Dept. of Social Services	Grapevine	Doctor	Other	**TOTAL**
prior to 1/8/99	336	N/A	N/A	N/A	N/A	N/A	N/A	N/A
1/8/99	232	8%	7%	62%	18%	3%	2%	100%
1/15/99	186	N/A	N/A	N/A	N/A	N/A	N/A	N/A
1/22/99	133	8%	10%	49%	16%	9%	8%	100%
1/29/99	128	25%	23%	20%	5%	13%	14%	100%
2/5/99	176	62%	14%	9%	5%	3%	7%	100%
2/12/99	162	54%	2%	12%	5%	10%	17%	100%
2/19/99	146	55%	10%	10%	9%	13%	3%	100%
2/26/99	150	41%	25%	13%	7%	14%	0%	100%
3/5/99	191	39%	20%	9%	12%	15%	5%	100%
3/12/99	175	44%	12%	14%	10%	13%	7%	100%
3/19/99	133	31%	18%	12%	8%	20%	11%	100%
3/26/99	146	42%	15%	10%	16%	9%	8%	100%
4/2/99	96	50%	17%	5%	9%	11%	8%	100%
4/9/99	90	37%	36%	2%	13%	9%	3%	100%
4/16/99	123	34%	22%	20%	11%	12%	1%	100%
4/23/99	146	24%	28%	8%	16%	24%	0%	100%
4/30/99	105	40%	23%	9%	15%	13%	0%	100%
5/7/99	83	23%	17%	15%	20%	23%	2%	100%
5/14/99	64	20%	22%	14%	17%	27%	0%	100%
5/21/99	76	19%	22%	12%	18%	29%	0%	100%
5/28/99	50	22%	18%	4%	24%	32%	0%	100%
6/4/99	48	19%	22%	19%	15%	25%	0%	100%
6/11/99	35	17%	29%	14%	26%	14%	0%	100%
6/18/99	63	13%	19%	21%	22%	25%	0%	100%
6/25/99	56	13%	20%	13%	31%	24%	0%	100%
7/2/99	49	8%	22%	16%	27%	27%	0%	100%
7/9/99	34	6%	6%	21%	41%	26%	0%	100%
7/16/99	49	6%	18%	27%	39%	10%	0%	100%
7/23/99	54	26%	11%	13%	28%	22%	0%	100%
7/30/99	58	9%	9%	24%	31%	28%	0%	100%
8/6/99	52	12%	10%	15%	38%	25%	0%	100%
8/13/99	59	7%	15%	22%	29%	27%	0%	100%
8/20/99	48	6%	6%	29%	21%	38%	0%	100%
8/27/99	70	3%	29%	17%	29%	23%	0%	100%
9/3/99	58	10%	22%	17%	33%	17%	0%	100%
9/10/99	74	11%	28%	19%	22%	20%	0%	100%
9/17/99	86	28%	17%	17%	21%	16%	0%	100%
9/24/99	86	40%	14%	5%	27%	15%	0%	100%
Total apps	4106							
Avg from referral source		24.6%	17.8%	16.7%	19.8%	18.5%	2.6%	100.0%

3.4.5 Have any of the outreach activities been more successful in reaching certain populations? Which methods best reached which populations? How have you measured their effectiveness? Please present quantitative findings where available.

See 3.4.3.

As the application statistics show, the school based outreach had an immediate impact on increasing applications. On average, 26% of our applicants in 1999 received program information through their school. We know the number of applicants responding to specific outreach activities: radio, media advertising (18% of applicants), providers (19%) or friends and family (20%). The increasing number of referrals from the "grapevine" demonstrates increased awareness from community outreach.

Tracking forms indicate that the Community agency that serves immigrants has been the most successful in the finder's fee pilot. Families will enroll when assisted by a trusted provider. See attached spreadsheet titled Agency Application Statistics for an example of what has happened since this project started on 09/01/99. More complete information will be available for the FFY '00 report. Please note that Westside Health Center, which serves a large number of immigrants, has received 80% of the dollars paid to 15 agencies.

Agency Application Statistics

PLEASE NOTE:

This chart identifies incentives paid to agencies from 9/01/99 – 1/20/00. No such information available for FFY '99 reporting year.

LOCATION	TOTAL APPS	TOTAL APPS WITH CHILDREN	TOTAL CHILDREN	TOTAL ADULTS	TOTAL PREGNANT WOMEN/ TEEN	APPS PENDING MORE INFO	APPS PENDING IN SYSTEM	# OF PEOPLE DENIED	CHILDREN APPROVED FOR MEDICAID	ADULTS/ PREG TEENS APPROVED FOR MEDICAID	APPS/CHILD# APPROVED FOR SCHIPS	APPS/CHILD ENROLLED IN SCHIPS	CREDIT FOR ENROLL	AMOUNT PAID	AMOUNT DUE	CHILDREN PREVIOUSLY ENROLLED
Brandywine Community Center	9	9	19	2	0	3	1	0	7	1	2/3	0	5	$100	$150	1
Children and Families First	3	3	5	1	0	1	0	0	0	0	1/2	0	0	$0	$0	2
Edgemoor Community	0	0	0	0	0	0	0	0	0	0	0	0	0	$0	$0	0
Girls Inc	4	4	8	1	0	2	2	0	0	0	0	0	0	$0	$0	0
Henrietta Johnson	5	5	7	2	0	0	0	0	2	2	3/5	1/2	3	$0	$150	0
Kingswood Community	0	0	0	0	0	0	0	0	0	0	0	0	0	$0	$0	0
Latin American Community	4	4	13	2	0	1	1	1	6	0	1/3	1/3	3	$150	$0	0
Ministry of Caring	18	8	10	17	0	4	2	1	2	7	2/2	0	2	$0	$100	2
Neighborhood House	1	1	3	0	0	0	0	0	3	0	0	0	1	$0	$50	0
New Castle County Head Start	1	1	4	0	0	0	0	0	4	0	0	0	1	$50	$0	0
Westend Neighborhood House	2	2	6	1	0	0	0	2	4	1	0	0	1	$0	$50	0
Westside Health	112	76	109	51	37	15	15	18	51	48	1/2	0	41	$900	$1,150	16
Wlm. "Hicks" Anderson	1	1	3	2	0	0	0	2	1	0	1/2	0	1	$0	$50	0
Wilmington Head Start	4	4	11	1	0	4	0	0	0	0	0	0	0	$0	$0	0
YWCA	1	1	1	0	0	0	0	0	0	0	1/1	0	0	$0	$0	0
MISC.	4	3	6	0	0	0	2	0	1	0	1/1	0	0	$0	$0	1
Total	**169**	**122**	**205**	**80**	**37**	**30**	**23**	**24**	**81**	**59**	**12/21**	**2/5**	**58**	**$1,200**	**$1,700**	**22**

3.5 What other health programs are available to SCHIP eligibles and how *does Delaware* coordinate with them? (Section 2108(b)(1)(D))

See Table 3.5 identifying areas of coordination between SCHIP and other programs (such as Medicaid, MCH, WIC, School Lunch).

Table 3.5

Type of coordination	Medicaid	Maternal and child health	Other (specify) *Schools*	Other (specify) *Nemours Childrens' Health Clinics*
Administration	Ö			
Outreach	Ö	Ö	Ö	Ö
Eligibility determination	Ö	Ö	Ö	Ö
Service delivery	Ö			Ö
Procurement	Ö			
Contracting	Ö			
Data collection	Ö	Ö		
Quality assurance	Ö			
Other (specify) *N/A*				

3.6 How *does Delaware* avoid crowd-out of private insurance?

3.6.1 Describe anti-crowd-out policies implemented by *Delaware's* SCHIP program.

__√___Eligibility determination process:
- _√_ Waiting period without health insurance (specify) *6 months*
- _√_ Information on current or previous health insurance gathered on application (specify)
- ___ Information verified with employer (specify)
- ___ Records match (specify)
- ___ Other (specify)
- ___ Other (specify)

__√___Benefit package design:
- ___ Benefit limits (specify)
- _√_ Cost-sharing (specify) *premiums*
- ___ Other (specify)
- ___ Other (specify)

_____Other policies intended to avoid crowd out (e.g., insurance reform):
- ___ Other (specify)
- ___ Other (specify)

3.6.2 How *does Delaware* monitor crowd-out? What have you found? Please attach any available reports or other documentation.

To be determined

SECTION 4. PROGRAM ASSESSMENT

This section is designed to assess the effectiveness of *Delaware's* SCHIP program(s), including enrollment, disenrollment, expenditures, access to care, and quality of care.

4.1 Who enrolled in *Delaware's* SCHIP program?

4.1.1 What are the characteristics of children enrolled in *Delaware's* SCHIP program? (Section 2108(b)(1)(B)(i))

See Table 4.1.1 for *Delaware's* SCHIP program, based on data from *Delaware's* HCFA quarterly enrollment reports (HCFA Form 21E).

Table 4.1.1 SCHIP Program Type *State Designed SCHIP Program*

Characteristics	Number of children ever enrolled		Average number of Months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999 *	FFY 1998	FFY 1999 *	FFY 1998	FFY 1999 *
All Children	*N/A*	*2,433*	*N/A*	*4.95*	*N/A*	*2,033***
Age						
Under 1	*N/A*	*11*	*N/A*	*3.73*	*N/A*	
1-5	*N/A*	*626*	*N/A*	*4.65*	*N/A*	
6-12	*N/A*	*1180*	*N/A*	*5.14*	*N/A*	
13-18	*N/A*	*616*	*N/A*	*4.91*	*N/A*	
Countable Income Level*						
At or below 150% FPL	*N/A*	*1,654*	*N/A*	*4.28*	*N/A*	
Above 150% FPL	*N/A*	*779*	*N/A*	*5.08*	*N/A*	
Age and Income						
Under 1						
At or below 150% FPL	*N/A*	*4*	*N/A*	*3.75*	*N/A*	
Above 150% FPL	*N/A*	*7*	*N/A*	*3.71*	*N/A*	
1-5						
At or below 150% FPL	*N/A*	*280*	*N/A*	*4.7*	*N/A*	
Above 150% FPL	*N/A*	*346*	*N/A*	*4.63*	*N/A*	
6-12						
At or below 150% FPL	*N/A*	*892*	*N/A*	*5.02*	*N/A*	
Above 150% FPL	*N/A*	*288*	*N/A*	*5.49*	*N/A*	
13-18						
At or below 150% FPL	*N/A*	*478*	*N/A*	*4.77*	*N/A*	
Above 150% FPL	*N/A*	*138*	*N/A*	*5.41*	*N/A*	
Type of plan						
Fee-for-service	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*
Managed care	*N/A*	*2,433*	*N/A*	*4.95*	*N/A*	
PCCM	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*

See attached
***** Breakdown of disenrollee data not available***

* *The data from which the 21E report is produced does not currently calculate line 6. The problem is being corrected, but Delaware is unable to retroactively correct the data for FFY '99. Therefore, a DB2 analysis was done to create line 6.*

1. *One solution is to use the number of children **ever enrolled** derived from the total in the 2nd quarter of FFY '99 (which was the first quarter in which the DHCP was operational) and add in the new enrollees from the 3rd and 4th quarters. This will overstate the total ever enrolled, as it is not unduplicated, and, as a result, will understate the average number of months of enrollment for individual age cohorts.*

Characteristics	Number of children ever enrolled		% of total
	FFY 1998	FFY 1999*	
All Children	*N/A*	*4,095*	
Age			
Under 1	*N/A*	*18*	*.45%*
1-5	*N/A*	*1,053*	*25.71%*
6-12	*N/A*	*1,987*	*48.52%*
13-18	*N/A*	*1,037*	*25.32%*
Countable Income Level*			
At or below 150% FPL	*N/A*	*2,784*	*67.99%*
Above 150% FPL	*N/A*	*1,311*	*32.01%*
Age and Income			
Under 1			
At or below 150% FPL	*N/A*	*7*	*.17%*
Above 150% FPL	*N/A*	*11*	*.27%*
1-5			
At or below 150% FPL	*N/A*	*472*	*11.53%*
Above 150% FPL	*N/A*	*581*	*14.19%*
6-12			
At or below 150% FPL	*N/A*	*1,501*	*36.65%*
Above 150% FPL	*N/A*	*486*	*11.87%*
13-18			
At or below 150% FPL	*N/A*	*804*	*19.63%*
Above 150% FPL	*N/A*	*233*	*5.69%*

2. *A second solution is to use the resultant figures from solution #1, determine the percentage they are of the overstated total, and apply those percentages to the numbers in line 6 of the HCFA 21E report.*

Table 4.1.1 reflects solution #2, which is Delaware's most accurate estimation.

<u>Please note</u> that in the HCFA 21E report the number of disenrollments is artificially high due to a conversion to a new eligibility system which converted children from Medicaid to SCHIP erroneously. The children were converted back to Medicaid almost immediately, but the data shows these as disenrollments for the FFY '99 reporting period. In addition, the numbers count many children with 1 month or less of SCHIP coverage when they shouldn't have been counted in the data at all. There is no remedy for FFY '99 and Delaware is unable to retroactively correct this information.

This problem will be fixed for the FFY '00 reporting period.

SOURCE: HCFA-21E

4.1.2 How many SCHIP enrollees had access to or coverage by health insurance prior to enrollment in SCHIP? Please indicate the source of these data (e.g., application form, survey). (Section 2108(b)(1)(B)(i))

More than 50% of DHCP enrollees transitioned from Medicaid immediately after losing Medicaid eligibility. The future baseline DHCP survey report will include information on prior insurance available to families enrolling through the application process.

4.1.3 What is the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children? (Section 2108(b)(1)(C))
Private sector currently unknown. Medicaid increased enrollment by 2,124 through the first 7 months of DHCP operation. See Section 1.2.

4.2 Who disenrolled from *Delaware's* SCHIP program and why?

As of September 30, 1999, 1,213 children (one third of those ever enrolled) had disenrolled from the DHCP. The disenrollees by income are 50% from the lowest income group, 34% from the middle income group, and 16% from the families with the highest income.

Sampling studies show at least one third of the disenrolled clients would not be candidates to continue in the DHCP program because:

- *they transitioned back to Medicaid*
- *they had other primary insurance when they transitioned to DHCP from Medicaid*
- *they were no longer eligible for Medicaid or DHCP.*

Current research will provide more information about the disenrolled children.

4.2.1 How many children disenrolled from *Delaware's* SCHIP program(s)? Please discuss disenrollment rates presented in Table 4.1.1. Was disenrollment higher or lower than expected? How do SCHIP disenrollment rates compare to traditional Medicaid disenrollment rates?

See 4.2. Disenrollment was higher than expected due to:

- *the movement of clients between the Medicaid and DHCP programs*
- *the lack of understanding for families enrolling directly from Medicaid*

4.2.2 How many children did not re-enroll at renewal? How many of the children who did not re-enroll got other coverage when they left SCHIP?

Data is not yet available.

4.2.2 What were the reasons for discontinuation of coverage under SCHIP? (Please specify data source, methodologies, and reporting period.)

Delaware is currently studying the DHCP disenrollments and contacting the families for further insight and data. Through September 30, 1999 a total of 1,213 children had disenrolled from the DHCP (As of January 30, 2000 a total of 2,033 have disenrolled.). A detailed review of the May and September, 1999 disenrollments shows approximately 30% of the children are enrolled in Medicaid, 21% are no longer eligible for DHCP or Medicaid, 8% had access to other insurance, and 40% disenrolled for currently unknown reasons. We are contacting these families to identify the reasons for their disenrollment: premium, move, new accessible benefits, misunderstanding. The results of this outreach will be available in the future.

Table 4.2.3		
Reason for discontinuation of coverage	State-designed SCHIP Program	
	Number of disenrollees	Percent of total
Total	2033	100%
Access to commercial insurance	163	8%
Eligible for Medicaid	630	31%
Income too high		
Aged out of program		
Moved/died		
Nonpayment of premium		
Incomplete documentation		
Did not reply/unable to contact		
Other (specify) *No longer eligible due to income, age, or move out of state*	427	21%
Other (specify) *Currently being researched through client contact, could be premium unaffordable, move out of state, new employment with benefits, lack of understanding*	813	40%
Don't know		

4.2.4 What steps is *Delaware* taking to ensure that children who disenroll, but are still eligible, re-enroll?

Delaware is encouraging re-enrollment through several measures:

- *Delaware eliminated the six month re-enrollment waiting period for families who disenrolled due to nonpayment of premium.*
- *Each disenrolling family is sent a letter confirming the disenrollment. The letter encourages the family to call the Health Benefits Manager to discuss family, income, or premium issues.*
- *A study is underway to better understand the disenrollments; every disenrolled family will be contacted. The result will be family re-enrollment or data explaining the disenrollment dynamic.*
- *All processes and forms are being reviewed and improved to facilitate client understanding of enrollment, premium, disenrollment, and available assistance.*

4.3 How much did you spend on *Delaware's* SCHIP program?

4.3.1 What were the total expenditures for *Delaware's* SCHIP program in federal fiscal year (FFY) 1998 and 1999?

FFY 1998 $0

FFY 1999 $1,359,806*

See Table 4.3.1 for each of *Delaware's* SCHIP programs and summarized expenditures by category (total computable expenditures and federal share

Table 4.3.1 SCHIP Program Type *State Designed SCHIP Program*

Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Total expenditures	*N/A*	*$1,089,745*	*N/A*	*$708,334*
Premiums for private health insurance (net of cost-sharing offsets)*				
Fee-for-service expenditures (subtotal)				
Inpatient hospital services				
Inpatient mental health facility services				
Nursing care services				
Physician and surgical services				
Outpatient hospital services				
Outpatient mental health facility services				
Prescribed drugs		*$190,000*		*$123,500*
Dental services				
Vision services				
Other practitioners' services				
Clinic services				
Therapy and rehabilitation services				
Laboratory and radiological services				
Durable and disposable medical equipment				
Family planning				
Abortions				
Screening services				
Home health				
Home and community-based services				
Hospice				
Medical transportation				
Case management				
Other services *Managed care capitation payments*		*$899,745*		*$584,834*

*** includes admin costs**

4.3.2 What were the total expenditures that applied to the 10 percent limit? Please complete Table 4.3.2 and summarize expenditures by category. * *States were granted three years over which to spread the 10% cap on administration.*

What types of activities were funded under the 10 percent cap? *Systems modifications to the DCIS II and the MMIS, outreach & eligibility determination activities.*

What role did the 10 percent cap have in program design? *The State decided that it would use all state dollars, if necessary, to get the program up and running.*

Table 4.3.2		
Type of expenditure	State-designed *SCHIP* Program	
	FY 1998	FY 1999
Total computable share	*N/A*	*$270,061*
Outreach		*
Administration		*
Other_____		
Federal share		*$175,540*
Outreach		*
Administration		*
Other _____		

* *Unable to break out outreach and other administrative costs.*

4.3.3 What were the non-Federal sources of funds spent on *Delaware's* SCHIP program (Section 2108(b)(1)(B)(vii))

_√_ State appropriations
___ County/local funds
___ Employer contributions
_√__ Foundation grants
___ Private donations (such as United Way, sponsorship)
___ Other (specify) _____

4.4 How are you assuring SCHIP enrollees have access to care?

4.4.1 What processes are being used to monitor and evaluate access to care received by SCHIP enrollees? Please specify each delivery system used (from question 3.2.3) if approaches vary by the delivery system within each program. For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in fee-for-service, specify 'FFS.' If an approach is used in a Primary Care Case Management program, specify 'PCCM.'

Information not available for FFY '99. EQRO and client survey to be conducted in FFY '00.

Table 4.4.1

Approaches to monitoring access	State-designed SCHIP Program
Appointment audits	*N/A*
PCP/enrollee ratios	*N/A*
Time/distance standards	*N/A*
Urgent/routine care access standards	*N/A*
Network capacity reviews (rural providers, safety net providers, specialty mix)	*N/A*
Complaint/grievance/ Disenrollment reviews	*N/A*
Case file reviews	*N/A*
Beneficiary surveys	*N/A*
Utilization analysis (emergency room use, preventive care use)	*N/A*
Other (specify) _____	*N/A*
Other (specify) _____	*N/A*

4.4.2 What kind of managed care utilization data are you collecting for each of *Delaware's* SCHIP programs? If your State has no contracts with health plans, skip to section 4.4.3.

Table 4.4.2

Type of utilization data	State-designed SCHIP Program
Requiring submission of raw encounter data by health plans	_√_ Yes ___ No
Requiring submission of aggregate HEDIS data by health plans	___ Yes _√_ No
Other (specify) *MCO financial reports of medical loss ratio*	_√_ Yes ___ No

4.4.3 What information (if any) is currently available on access to care by SCHIP enrollees in *Delaware*? Please summarize the results.

HBM and Customer Service complaint records – results not yet evaluated.

4.4.4 What plans does *Delaware's* SCHIP program have for future monitoring/evaluation of access to care by SCHIP enrollees? When will data be available?

- *Client survey*
- *EQRO study*
- *Review of encounter data*
- *Assessment of how many children change plans, and why, during the 2001 open enrollment*

Available at end of 2000.

4.5 How are you measuring the quality of care received by SCHIP enrollees?

4.5.1 What processes are you using to monitor and evaluate quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, and immunizations? Please specify the approaches used to monitor quality within each delivery system (from question 3.2.3). For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in fee-for-service, specify 'FFS.' If an approach is used in primary care case management, specify 'PCCM.'

Too early in program to measure – see 4.4.4

Approaches to monitoring quality	State-designed SCHIP Program
Focused studies (specify)	*N/A*
Client satisfaction surveys	*N/A*
Complaint/grievance/disenrollment reviews	*N/A*
Sentinel event reviews	*N/A*
Plan site visits	*N/A*
Case file reviews	*N/A*
Independent peer review	*N/A*
HEDIS performance measurement	*N/A*
Other performance measurement (specify)	*N/A*
Other (specify) _____	*N/A*
Other (specify) _____	*N/A*
Other (specify) _____	*N/A*

4.5.2 What information (if any) is currently available on quality of care received by SCHIP enrollees in *Delaware*? Please summarize the results.

See 4.4.3

4.5.3 What plans does *Delaware's* SCHIP program have for future monitoring/evaluation of quality of care received by SCHIP enrollees? When will data be available?

See 4.4.4

4.6 Please attach any reports or other documents addressing access, quality, utilization, costs, satisfaction, or other aspects of *Delaware's* SCHIP program's performance. Please list attachments here.

SECTION 5. REFLECTIONS

This section is designed to identify lessons learned by the State during the early implementation of its SCHIP program as well as to discuss ways in which the State plans to improve its SCHIP program in the future. The State evaluation concludes with recommendations of how the Title XXI program could be improved.

5.1 What worked and what didn't work when designing and implementing Delaware's SCHIP program? lessons learned? "best practices"? evaluation efforts have been completed, are underway, or planned to analyze what worked and what didn't work.

5.1.1 Eligibility Determination/Redetermination and Enrollment:

What worked? (best practices)

- *Simplified application*
- *Centralized 800 phone number for information and application*
- *Completion of the application with callers in initial phone call*
- *Review of all applications for Medicaid eligibility*
- *Simplified enrollment instructions*
- *Transition of clients losing Medicaid eligibility to DHCP*
- *Phone conversations with enrolling families to educate them on managed care, their new health plan, and the premium process*
- *Policy to allow immediate re-enrollment for cases that have cancelled for nonpayment.*
- *Tracking of inquiring calls and applications, which provided important data about the applicants and program, including effective referral sources, zipcode concentrations, applicants enrollment in a variety of medical assistance programs, denials.*
- *Using the same MCOs in DHCP that are used in Medicaid managed care; keeps families together in the same MCO and with same PCP.*
- *Implementing Medicaid "lookalike" plan; minimizes benefit confusion.*

What didn't work?

The following processes work, but are being reviewed for process and communication improvements to enable smoother enrollment and better understanding:

- *Verification Requirements*
- *Notices and outreach to families transitioning to DHCP from Medicaid*
- *The requirement for a premium for the lowest income enrollees*
- *Client notices, premium, re-determination, disenrollment, to ensure they provide messages of encouragement*

What evaluation has been completed?

Evaluation has been constant and ongoing through controls that are part of our program, including a weekly application report, tracking of applications returned in the business reply envelopes provided, follow-up calls to unenrolled but approved families, and a monthly enrollment activity report.

Resources are being identified to contact families that somehow touched the DHCP but have "slipped away", including those who did not return applications, those denied because they did not send necessary verifications, those approved who did not enroll, and those who have disenrolled. The result of this project will be increased enrollment as well as clear data on what are the issues and obstacles in our application and enrollment processes.

5.1.2 Outreach

What worked?

- *Public / private partnership to conduct program outreach, including Division of Social Service, Division of Public Health, EDS, and community groups and providers;*
- *School-based outreach coordinated with the school nurses;*
- *Leveraging existing government databases for mailing program information, including Child Support, WIC, food stamps, licensed day cares;*
- *Weekly training sessions that introduced the program to a mix of public, community, and private representatives to increase statewide awareness;*
- *Statewide media campaign, including print materials, radio, tv, billboards, bus signs.*

What didn't work?

- *Health Fairs proved to be good locations for sharing information, but poor locations for gathering completed applications.*
- *Our broad outreach, including the media campaign and multiple, various distribution of program materials was effective in getting applications from families in need of insurance due to family medical issues, but perhaps less effective in getting families with well kids enrolled.*

What evaluation has been completed?

Each week the Health Benefits Manager reports the number of applications mailed along with specific data, showing where families heard about the program. The reports show the success of the outreach measured by number of applications

mailed as well as the most effective channels of outreach.

5.1.3 Benefit Structure

At enrollment, families are very pleased with the benefits provided, including routine care, pharmacy, mental health treatment, and coverage for major medical services. Families would like to see dental coverage included in the benefit package.

5.1.4 Cost-Sharing (such as premiums, copayments, compliance with 5% cap)

Additional study is underway to determine the effect of premiums on disenrollment. Copayments are not an issue in Delaware since the DHCP has only one copayment for inappropriate use of the emergency room. The program premium structure was designed to eliminate compliance with the 5% cap as an issue.

The DHCP offers a payment incentive: pay for three months get a fourth month free. The incentive is viewed as supportive to the families. Approximately 10% of enrolled families use the incentive offer.

5.1.5 Delivery System

The DHCP leveraged the Medicaid delivery system, including enrollment broker and managed care organizations.

5.1.6 Coordination with Other Programs (especially private insurance and crowd-out)

DHCP does include a 6 month crowd-out provision. Applicants are asked about other insurance and past insurance for their children. Children transitioned from Medicaid with other insurance are disenrolled from the DHCP.

5.1.7 Evaluation and Monitoring (including data reporting)

5.1.8 Other (specify)

5.2 What plans does Delaware have for "improving the availability of health insurance and health care for children"? (Section 2108(b)(1)(F))

Continued aggressive outreach activities for DHCP and Medicaid, but larger "uninsured" issues are still To-Be-Determined. The Delaware Health Care Commission is working with the Tobacco Fund Advisory Council to determine how much of the money will be used to

"fill the gaps" for the uninsured in the State; i.e.: funding may be used to cover adults in families who have children in DHCP or may be used for implementation of the Work Incentive Improvement Act of 1999.

5.3 What recommendations does Delaware have for improving the Title XXI program? (Section 2108(b)(1)(G))

- *We are estimating the impact and cost for reduction or elimination of premiums for the lowest income families. We are considering elimination of premiums up to either the 133% or 150% of FPL.*

- *We plan to determine the benefits and risks to allow declaration of income for applications and redeterminations . We will track applications to determine if verification of income was eliminated how many applications would be processed quicker and would the length of processing time be reduced. We are comparing listed income on the application with actual income to determine our vulnerability to sanctions for errors.*

- *We are estimating the impact and cost of implementing a "good cause" provision, which would allow families to drop excessively expensive private insurance to qualify for DHCP. We may consider as a benchmark of excessively expensive premiums costs which exceed 7.5% of a family's income. This is the amount used in recently passed Ticket to Work legislation.*